Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
PROFESSIONAL VISITS											
8129	Office/hospital visit – after regularly scheduled hours	06.03	190.80 (167.40)								B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to appropriate code numbers for actual services rendered. After regularly scheduled hours is definend as weekends and night visits between 18h00 and 07h00 the following day. Limitation: Code 8129 may only be reported for emergency treatment rendered outside normal working hours. Not applicable where a practice offers an extended hours service as the norm.										
8140	House/extended care facility/hospital call	06.03	126.30 (110.80)			126.30 (110.80)					B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report per visit in addition to reporting appropriate code numbers for actual services performed. Limitation: The fee/benefit for house/extended care facility/hospital calls are limited to five calls per treatment plan.										
8903	House/Hosp/Nursing home consultation - MFOS	04.00		141.40 (124.00)							S
8904	House/Hosp/Nursing home consultation (subsequent) - MFOS	06.03		94.00 (82.50)							S
	"Subsequent consultation" shall mean, in connection with items 8904 and 8907, a consultation for the same pathological condition provided that such consultation occurs within six months of the first consultation.										
8905	After regularly hours consultation - MFOS	04.00		207.10 (181.60)							S
8907	House/Hosp/Nursing home consultation (maximum per week) - MFOS	06.03		235.40 (206.50)							S
	See Code 8904 descriptor.										
9203	House/Hosp/Nursing home consultation - Oral pathologist	04.00						141.40 (124.00)			
9207	After hours visit - Oral pathologist	04.00						207.10 (181.60)			
DRUGS, MEDICAMENTS AND MATERIALS											
8109	Infection control/barrier techniques	06.03	11.40 (9.99)								B
	Comment: This is typically reported on a "per visit" basis for new rubber gloves, masks, etc. provided by the dentist. Report per provider per visit.										
8110	Sterilized instrumentation	06.03	29.40 (25.80)								S
	Limitation: The use of this code is limited to autoclaved, vapour or heat sterilised instruments (i.e. set(s) of long handled instruments and/or forceps) provided by the dentist/hygienist for use in the surgery. Report per visit.										
8183	Therapeutic drug injection	06.03	34.20 (30.00)								B
	Not applicable to local anaesthetic.										
8220	Cost of suture material	06.03	-	-		-					B
	Comment: Use in conjunction with procedure(s) when suture material is provided by the practitioner. Report per pack. See Rule 002 and Modifier 8025 for direct material costs.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8304	Rubber dam per arch	06.03	60.80 (53.30)								B
	The use of this code is limited to selected procedures for benefit purposes. These procedures are identified throughout the NHRPL.										
8306	Cost of MTA	06.03	-				-				B
	Comment: See Rule 002 and Modifier 8025 for direct material costs.										
8310	Supply of bleaching materials	06.03	-								
	See Rule 002 and Modifier 8025 for direct material costs. Limitation: Benefit by arrangement.										
ADMINISTRATIVE AND LABORATORY SERVICES											
8099	Dental laboratory service	06.03	-	-	-	-	-				
	Use to submit dental laboratory services. See Rule 003.										
8106	Special report	06.03	130.10 (114.10)	130.10 (114.10)	130.10 (114.10)	130.10 (114.10)	130.10 (114.10)				A
	Special written reports such as insurance forms requiring more than the information conveyed in the usual dental communications or standard reporting form. Excludes pre-treatment estimate and orthodontic treatment/payment plan.										
8111	Dental testimony	06.03									
	Use to report dento-legal fees when the practitioner is present at Court at the request of an advocate or attorney. Report per hour.										
8120	Treatment plan completed	06.03	-	-	-	-	-				
	Use to report the completion of a treatment plan effected from an oral evaluation – See Rule 008.										
8139	Appointment not kept /30min	06.03	-	-	-	-	-				B
	Comment: By arrangement with patient										
MISCELLANEOUS SERVICES											
Palliative Treatment											
8131	Emergency dental treatment	06.03	77.80 (68.20)				158.60 (139.10)		T		B
	This code is intended to be used for emergency treatment to alleviate dental pain but is not curative - report per visit. This code should not be used when more adequately described procedures exists and may not be reported with other procedure codes (diagnostic procedures and professional visits excluded).										
8166	Application of desensitising resin, per tooth	06.03	51.30 (45.00)						T		B
	This procedure involves the application of adhesive resins on a cervical and/or root surface and should not to be used for bases, liners, or adhesives under restorations - report per tooth.										
8167	Application of desensitising medicament, per visit	06.03	59.80 (52.50)								B
	This procedure involves the application of topical fluoride on teeth and/or root surfaces and should not to be used for bases, liners, or adhesives under restorations - report per visit (irrespective of number of teeth treated). The intention of this code is to treat persistent pain and not to prevent decay. Fluoride application is considered treatment for caries control – See codes 8161 and 8162. Comment: This code should not be reported together with codes 8161 and 8162.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8165	Sedative filling	06.03	77.80 (68.20)						T	+L	B
	The intention of this code is to report a temporary restoration to relieve pain. It should not be used as a temporary restoration in conjunction with root canal therapy, a base or liner under a restoration. Use this code to report a ZOE restoration or ART technique. May not be reported with other procedure codes on the same visit for a tooth.										
Post Surgical Complications											
8931	Treatment of post-extraction haemorrhage	06.03	57.00 (50.00)	341.80 (299.90)							S
	Involves the treatment of local haemorrhage following extraction. Report per visit. Excludes treatment of bleeding in the case of blood dyscrasias (8933), e.g. haemophilia. Routine post operative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for the surgical service.										
8933	Treatment of haemorrhage (blood dyscracias)	04.00	788.10 (691.30)	1182.10 (1036.90)							S
8935	Treatment of septic socket	06.03	57.00 (50.00)	89.30 (78.30)							S
	Involves the treatment of localised inflammation of the tooth socket following extraction due to infection or loss of blood clot; osteitis. Report per visit. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for, the surgical service.										
Bleaching											
8308	External bleaching - per arch	06.03							M		A
	Comment: (1) The unpredictability and lack of permanence of this procedure should be pointed out, and alternative procedures discussed with the patient. (2) The benefits provided by some medical schemes for external bleaching may be subject to pre-authorisation.										
8309	Home bleaching - instructions and applicator	06.03								+L	A
	See code 8310 in the section 'Adjunctive general services' for materials supplied Limitation: Benefits by arrangement.										
8311	Home bleaching - subsequent visit	06.03									A
	Limitation: A maximum of three additional visits may be charged. Benefits by arrangement.										
8325	Internal bleaching - per tooth	06.03	184.20 (161.60)				276.40 (242.40)		T		A
	Report code 8304 (application of a rubber dam) in addition to this code.										
8327	Internal bleaching - each additional visit	06.03	88.30 (77.50)				132.50 (116.20)		T		A
	Comment: (1) Report the application of a rubber dam code (8304) in addition to this code. (2) The submission of fees is limited to two additional visits.										
Unclassified Treatment											
8158	Enamel microabrasion	06.03	71.20 (62.40)								
	This procedure involves the removal of superficial enamel defects due to decalcification or altered mineralisation. It is typically used for complex procedures when removing stain from anterior teeth (e.g., fluorosis stain) and should not be confused with air abrasion. Submit per visit.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8168	Behavior management	06.03									B
	Comment: (1) May be reported in addition to treatment provided, when the patient is developmentally disabled, mentally ill, or is especially uncooperative and difficult to manage, resulting in the dental staff providing additional time, skill and/or assistance to render treatment. (2) The Code can only be billed where an office treatment requires extraordinary effort and is the only alternative to general anaesthesia. Includes any and all pharmacological, psychological, physical management adjuncts required or utilised. (3) Notation and justification must be written in the patient record identifying the specific behaviour problem and the technique used to manage it. (4) Report in 15-minute units. (maximum 4 units per visit and allowed once per patient per day) Limit of 12 units per year. (5) If requested, the report must be made available at no charge. (6) The benefits provided by some medical schemes for behaviour management may be subject to pre-authorisation.										
8551	Occlusal adjustment - major	06.03	492.40 (432.00)		738.70 (648.00)		738.70 (648.00)				A
	Comment: (1) A complete occlusal adjustment involves the grinding of teeth to the equivalent of two or more quadrants. (2) Several appointments of varying length and sedation to attain relaxation of the muscularity muscles may be necessary. Submit code 8551 for payment at the last visit if several appointments to complete the procedure are required.										
8553	Occlusal adjustment - minor	06.03	171.80 (150.70)		235.40 (206.50)	235.40 (206.50)	235.40 (206.50)				A
	An occlusal adjustment involves the grinding of the occluding surfaces of teeth to develop harmonious relationships between each other, their supporting structures, muscles of mastication and temporomandibular joints. Comment: (1) Partial occlusal adjustment for the relief of symptomatic teeth involves the selective grinding of teeth to the equivalent of one quadrant or less. (2) Payment for this procedure is limited to one visit per treatment plan. (3) May not be submitted for the adjustment of dentures or restorations provided as part of a treatment plan (including opposing teeth).										
9099	Unlisted dental procedure or service (By report)	06.03	-								
	The intention of this code is to report a dental procedure or service which is not adequately described by a code. Describe procedure.										
MODIFIERS											
8001	Assistant surgeon - specialist (1/3 of the appropriate benefit)									06.03	
	Surgical assistant services should be identified by adding Modifier 8001 to the usual procedure code(s) – See Rule 009.										
8003	Minimum assistant surgeon	06.03	144.33 (126.61)	144.33 (126.61)		144.33 (126.61)					
	The minimum fee/benefit for surgical assistant services is identified by adding Modifier 8003 to the primary procedure code – See Rule 009.										
8005	Maximum multiple procedures (same incision) - MFO surgeon	06.03	224.08 (196.56)	224.08 (196.56)		224.08 (196.56)					
	When multiple surgical procedures through the same incision are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The maximum fee/benefit for each additional procedure should be identified by adding Modifier 8005 to the additional procedure code.										
8006	Multiple surgical procedures - third and subsequent procedures (50% of the appropriate benefit)									06.03	
	See Modifier 8009.										

Code	Description	Ver	General Dental Practice	Maxillo-facial and Oral Surgery	Orthodontics	Oral Medicine and Periodontics	Prosthodontics	Oral Pathology	MP	Lab	TC
8007	Assistant surgeon - general dental practitioner (15% of the appropriate benefit)										06.03
	Surgical assistant services should be identified by adding Modifier 8007 to the usual procedure code(s) – See Rule 009.										
8008	Emergency surgery - after hours (PLUS 25% of the appropriate benefit)										06.03
	When emergency surgery is performed after hours, such surgical procedures can be identified by adding Modifier 8008 to the procedure codes by each participating member of the surgical team.										
8009	Multiple surgical procedures - second procedure (75% of the appropriate benefit)										06.03
	When multiple procedures (under the same anaesthetic but through another incision) are performed on the same day or at the same session by the same provider, the primary procedure may be reported as listed. The additional procedures should be identified by adding the appropriate modifier (M8009 or M8006) to the additional procedure codes.										
8010	Open reduction (PLUS 75% of the appropriate benefit)										06.03
	When an open reduction is required for surgical procedures indicated in the schedule, the open reduction should be identified by adding Modifier 8010 in addition to the usual procedure code. TEMPORARY NOTE: Modifier 8010 applies only to codes 9035 and 9037. Two codes for "Open Reduction" was introduced so that the use of this modifier can be eliminated.										
8011	Procedure accompanied by unusual circumstances (Benefit PLUS X % as determined by the practitioner and agreed upon by patient/medical scheme)										06.03
	When the service provided by a practitioner is greater than that is usually required for the listed procedure, it may be identified by adding Modifier 8030 to the usual procedure code – See Rule 007.										
8012	Reduced services (benefit MINUS X % as determined by the practitioner)										06.03
	Under certain circumstances a service or procedure is partially reduced or eliminated at the practitioner's election. Under these circumstances the service provided can be identified by its usual procedure code and the addition of Modifier 8012, signifying the service is reduced.										
8013	Multiple modifiers										06.03
	Under certain circumstances two or more modifiers may be necessary to completely delineate a service. In such situations Modifier 8013 should be added to the basic procedure and the other applicable modifiers may be listed as part of the description of the service.										
8023	Fabrication of inlay/onlay (PLUS 25% of the appropriate benefit)										06.03
	When the direct technique is used to provide resin based inlays/onlays (see codes 8381 to 8384), laboratory costs do not apply. An additional fee may be levied by adding Modifier 8023 to the appropriate inlay/onlay codes.										
8025	Handling fee - direct materials (26% of material cost to a maximum of R26.00)	06.03	-	-		-	-				
	When listed direct dental materials are provided by the practitioner, a handling fee may be levied by reporting Modifier 8025 in addition to the appropriate direct material code – See Rule 002.										

DENTAL TECHNICIANS

Dental Technicians 2009

DRAFT NATIONAL REFERENCE PRICE LIST FOR DENTAL TECHNICIANS, EFFECTIVE FROM 1 JANUARY 2009

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

1	**Preparatory Work**				
The following section includes comsumables, however it excludes materials					
Code	**Description**	**Ver**	**Add**	**Dental Technology**	
				RVU	**Fee**
9301	Casting and trimming of model in plaster (yellow/white), per model	09.00		2.714	22.20 (19.40)
9303	Casting and trimming of model in super-hard stone (die-stone) per model	09.00		3.857	31.50 (27.60)
9305	Casting and trimming of study model, per model	09.00		7.143	58.30 (51.20)
9307	Casting and trimming of gnathostatic model, per model.	09.00		9.286	75.80 (66.50)
9309	New trimmed base to supplied model, per model	09.00		3.286	26.80 (23.50)
9311	Trimming of supplied model, per model	09.00		2.000	16.30 (14.30)
9312	Gingival tissue mask per implant	09.00		15.429	126.00 (110.50)
9313	Duplicating model, per model	09.00		8.286	67.70 (59.40)
9314	Refractory model, per unit	09.00		8.143	66.50 (58.30)
9315	Models and duplicate models (virgin model) for crown and bridge, work inclusive of one removable die	09.00		11.286	92.20 (80.90)
9317	Sectional models for crown and bridge, work inclusive of one removable die	09.00		10.000	81.70 (71.60)
9319	Each additional removable die for items 9315 and 9317 per die	09.00	+	2.571	21.00 (18.40)
9320	Indexed or model tray per die (not more than 9319)	09.00		2.571	21.00 (18.40)
9321	Occlusion block, per block	09.00		9.857	80.50 (70.60)
9323	Occlusion block on baseplate, per block	09.00		12.429	101.50 (89.00)
9327	Infection control per impression, denture (wax or acrylic) or any item in contact with body fluids	09.00		1.857	15.20 (13.30)
9329	Fit and supply of disposable articulator	09.00		4.857	39.70 (34.80)
9330	Delivery / Collection fee per completed procedure (maximum 4)	09.00		5.143	42.00 (36.80)
	The tariff under all sections excludes the fees for models - occlusion blocks and delivery charge.	09.00			
2	**Prosthetic Services Using Acrylic**				
	The tariff under this section excludes the fees for models and occlusion blocks.				09.00
	The following section includes consumables, however it excludes materials				09.00
A	**Full Dentures**				
9331	Full upper and lower dentures	09.00		132.571	1082.70 (949.70)
9333	Full upper or lower denture	09.00		77.571	633.50 (555.70)
9335	Set-up and waxing of full upper and lower dentures	09.00		45.714	373.30 (327.50)
9337	Set-up and waxing of full upper or lower denture	09.00		30.571	249.70 (219.00)
9339	Waxing and finishing of full upper and lower dentures	09.00		81.286	663.90 (582.30)
9341	Waxing and finishing of full upper or lower denture	09.00		45.429	371.00 (325.50)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9343	Additional fee for dentures on fully adjustable articulator at request of dentist	09.00	+	129.429	1057.00 (927.20)
9345	Additional fee for immediate dentures, or tooth socketed	09.00	+	1.857	15.20 (13.30)
9346	Additional fee for immediate dentures, per tooth not socketed.	09.00	+	1.000	8.17 (7.16)
9347	Additional fee for each retry from the third and upwards at an agreed quantum of time to be calculated at hourly rate	09.00	+	29.429	240.30 (210.80)
B	**Partial Dentures**				
9351	Set-up and finish of one-tooth denture	09.00		35.571	290.50 (254.80)
9352	Set-up and finish of two-tooth denture	09.00		37.857	309.20 (271.20)
9353	Set-up and finish of three-tooth denture	09.00		40.571	331.30 (290.70)
9354	Set-up and finish of four-tooth denture	09.00		42.857	350.00 (307.00)
9355	Set-up and finish of five-tooth denture	09.00		46.286	378.00 (331.60)
9356	Set-up and finish of six-tooth denture	09.00		55.286	451.50 (396.10)
9357	Set-up and finish of seven-tooth denture	09.00		65.714	536.70 (470.80)
9358	Set-up and finish of eight-tooth denture	09.00		69.714	569.40 (499.40)
9359	Set-up and finish nine or more tooth denture	09.00		71.429	583.40 (511.70)
9361	Set-up and waxing of one-tooth denture	09.00		10.143	82.80 (72.70)
9362	Set-up and waxing of two-tooth denture	09.00		12.286	100.30 (88.00)
9363	Set-up and waxing of three-tooth denture	09.00		14.000	114.30 (100.30)
9364	Set-up and waxing of four-tooth denture	09.00		16.286	133.00 (116.70)
9365	Set-up and waxing of five-tooth denture	09.00		18.000	147.00 (129.00)
9366	Set-up and waxing of six-tooth denture	09.00		21.286	173.80 (152.50)
9367	Set-up and waxing of seven-tooth denture	09.00		23.429	191.30 (167.80)
9368	Set-up and waxing of eight-tooth denture	09.00		25.143	205.30 (180.10)
9369	Set-up and waxing of nine or more tooth denture	09.00		26.857	219.30 (192.40)
9371	Waxing and finishing of one-tooth denture	09.00		27.857	227.50 (199.60)
9372	Waxing and finishing of two-tooth denture	09.00		28.429	232.20 (203.70)
9373	Waxing and finishing of three-tooth denture	09.00		28.857	235.70 (206.70)
9374	Waxing and finishing of four-tooth denture	09.00		29.429	240.30 (210.80)
9375	Waxing and finishing of five-tooth denture	09.00		30.571	249.70 (219.00)
9376	Waxing and finishing of six-tooth denture	09.00		31.714	259.00 (227.20)
9377	Waxing and finishing of seven-tooth denture	09.00		39.571	323.20 (283.50)
9378	Waxing and finishing of eighth-tooth denture	09.00		41.143	336.00 (294.70)
9379	Waxing and finishing of nine or more tooth denture	09.00		43.429	354.70 (311.10)
9383	Additional fee for finishing denture in tooth colour material, per tooth	09.00	+	6.857	56.00 (49.10)
9385	Additional fee for supplying finished denture on duplicate model	09.00	+	13.000	106.20 (93.10)
C	**Repair Service**				
9391	Basic charge which includes repair of one fracture, or addition of one tooth, or addition of one clasp	09.00		22.571	184.30 (161.70)
9393	Additional charge for each additional fracture, or tooth, or clasp	09.00	+	7.000	57.20 (50.10)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9395	Additional fee for using wire strengthener	09.00	+	8.000	65.30 (57.30)
9397	Additional fee for using pre-formed strengthener	09.00	+	8.571	70.00 (61.40)
9398	Additional fee for using mesh strengthener in repair procedure	09.00	+	13.571	110.80 (97.20)
D	**Additional Services**				
9401	Clear base	09.00		10.000	81.70 (71.60)
9403	Dox grinding of upper and lower dentures	09.00		12.714	103.80 (91.10)
9405	Inlay to artificial tooth, one surface only, per inlay	09.00		21.857	178.50 (156.60)
9406	Inlay to artificial tooth, multi-surfaces e.g. horseshoe or L-type inlay, per inlay	09.00		28.000	228.70 (200.60)
9407	Heka base technique per upper or lower denture	09.00		30.000	245.00 (214.90)
9409	Frego frame	09.00		13.000	106.20 (93.10)
9410	Bleaching tray	09.00		14.429	117.80 (103.40)
9411	Template per upper or lower denture	09.00		35.857	292.80 (256.90)
9413	Reline/rebase of single denture	09.00		45.143	368.70 (323.40)
9415	Remodel of single denture	09.00		69.429	567.00 (497.40)
9417	Soft base reline per denture	09.00		114.000	931.00 (816.70)
9419	Soft base to new denture, per denture	09.00		114.000	931.00 (816.70)
9421	Gum tinting per denture	09.00		21.143	172.70 (151.50)
9423	Lingual or palatal bar	09.00		17.000	138.80 (121.80)
9425	Cleaning and polishing of existing denture, per denture	09.00		13.857	113.20 (99.30)
9427	Mesh strengthener	09.00		11.857	96.80 (84.90)
9429	Theatre/ Consultation out of Laboratory per hour or part thereof	09.00		29.429	240.30 (210.80)
9431	Special Tray, acrylic, each	09.00		11.143	91.00 (79.80)
9432	Special Tray Light Cure, each	09.00		12.143	99.20 (87.00)
9433	Special Tray in base plate material, each	09.00		11.429	93.30 (81.90)
9435	Provision of single arm clasp, to partial denture	09.00		5.857	47.80 (42.00)
9437	Provision of double arm clasp, to partial denture	09.00		10.143	82.80 (72.70)
9439	Provision of single arm clasp with rest, to partial denture	09.00		13.143	107.30 (94.20)
9441	Provision of double arm clasp with rest, to partial denture	09.00		17.714	144.70 (126.90)
9443	Provision of preformed Roach clasp, to partial denture	09.00		7.571	61.80 (54.20)
9445	Provision of rest only to partial denture	09.00		7.571	61.80 (54.20)
9447	Cast Clasp	09.00		26.571	217.00 (190.40)
9448	Casting and trimming of Model from impression inside occlusion block or wax try in	09.00		4.857	39.70 (34.80)
9450	Finishing of acrylic work on any chrome cobalt or gold prosthesis	09.00		10.143	82.80 (72.70)
3	**Cobalt Chrome / Gold Prosthetic Services**				
	The tariffs under this section excludes the tariff for models.				09.00
	The following section includes consumables, however it excludes materials				09.00

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
A	**Full Metal Dentures**				
9451	Metal base for full upper or full lower denture each	09.00		91.000	743.20 (651.90)
B	**Partial Metal Dentures**				
9453	Basic charge - which excludes models and any special trays which may be required by the dentist, but includes refractory model	09.00		79.571	649.90 (570.00)
9455	Additional charge for each one arm clasp	09.00	+	3.286	26.80 (23.50)
9457	Additional charge for each Roach clasp	09.00	+	5.571	45.50 (39.90)
9459	Additional charge for each rest	09.00	+	3.000	24.50 (21.50)
9461	Additional charge for continuous clasp, per tooth	09.00	+	3.286	26.80 (23.50)
9463	Additional charge for lingual bar, per tooth passed	09.00	+	7.714	63.00 (55.30)
9465	Additional charge for palatal bar	09.00	+	12.286	100.30 (88.00)
9467	Additional charge for onlay	09.00	+	32.714	267.20 (234.40)
9469	Additional charge for saddle with finishing line, per tooth	09.00		5.429	44.30 (38.90)
9471	Additional charge for saddle without finishing line, per tooth	09.00		3.143	25.70 (22.50)
9473	Additional charge for horseshoe saddle, per tooth	09.00		5.429	44.30 (38.90)
9475	Additional charge for fitting of tooth to metal backing, per tooth	09.00		3.714	30.30 (26.60)
9479	Additional charge for fitting one distal-extension hinge	09.00	+	11.000	89.80 (78.80)
9480	Additional charge per milled edge per tooth	09.00	+	9.571	78.20 (68.60)
9481	Additional charge for each soldering joint	09.00	+	13.429	109.70 (96.20)
9483	Additional charge for soldering retention	09.00	+	16.286	133.00 (116.70)
9485	Additional charge for each additional retention soldering joint	09.00	+	5.000	40.80 (35.80)
9487	Additional charge for each welding joint	09.00	+	16.429	134.20 (117.70)
9489	Additional charge for fitting swing lock	09.00	+	13.429	109.70 (96.20)
9491	Additional charge for each backing cast	09.00	+	13.143	107.30 (94.20)
9493	Additional charge for each Steels backing or pontic cast (Plastic work to be charged in addition)	09.00	+	14.286	116.70 (102.30)
C	**Chrome Cobalt and Repairs**				
9495	Basic fee for the repairing of or addition to any appliance necessitating the casting of a model (9301)	09.00		20.714	169.20 (148.40)
9497	Basic fee if a new section is to be fabricated and where item 9495 does not apply (9301)	09.00		23.571	192.50 (168.90)
4	**Crown and Bridge Prosthetic Services**				
	The tariffs under this section excludes the tariff for models.				09.00
	The following section includes consumables, however it excludes materials				09.00
A	**Porcelain (Ceramic) Services**				
9501	Ceramic jacket crown/Ceromer crown or pontic	09.00		90.429	738.50 (647.80)
9502	Ceramic metal substitute coping	09.00		73.000	596.20 (523.00)
9505	Ceramic Bonded crown or pontic	09.00		119.429	975.40 (855.60)
9507	Post-solder invested joint, per joint	09.00		24.429	199.50 (175.00)
9511	Inlay in porcelain veneer crown	09.00		39.429	322.00 (282.50)
9512	Ceramic, inlay/onlay, bridge retainer	09.00		92.714	757.20 (664.20)
9515	Porcelain shoulder per unit (not applicable to pontics)	09.00		8.000	65.30 (57.30)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9520	Additional fee for crown- & bridge work performed on a movable condyle articulator per unit	09.00	+	3.857	31.50 (27.60)
B	**Gold and Acrylic Veneer Services**				
9521	Full metal crown, MOD, three-quarter crown	09.00		73.857	603.20 (529.10)
9524	Indirect Composite Resin inlay	09.00		20.000	163.30 (143.30)
9525	Class IV, MO, DO, cervical/occlusal inlay	09.00		60.857	497.00 (436.00)
9526	Additional fee for one piece casting of crown or inlay on post	09.00	+	18.571	151.70 (133.00)
9531	Pin-ledge inlay	09.00		69.000	563.50 (494.30)
9533	Full metal pontic	09.00		54.571	445.70 (390.90)
9535	Abutment thimble cast	09.00		51.143	417.70 (366.40)
9537	Precision lock and rest cast	09.00		72.571	592.70 (519.90)
9538	Lock and rest cast	09.00		34.714	283.50 (248.70)
9539	Casting of rest only	09.00		20.714	169.20 (148.40)
9541	Metal inlay or post, cast direct	09.00		22.000	179.70 (157.60)
9543	Gold/pre-solder invested joint	09.00		21.857	178.50 (156.60)
9545	Cast post with thimble, indirect	09.00		36.429	297.50 (261.00)
9546	Multiple Post	09.00		60.286	492.40 (431.90)
9547	Manufacture cast post and core to existing crown	09.00		47.571	388.50 (340.80)
9549	C.S.P. attachment (Steiger)	09.00		160.571	1311.40 (1150.30)
9550	Milling milled edge per unit	09.00		51.143	417.70 (366.40)
9551	Telescope crown	09.00		126.000	1029.00 (902.70)
9553	Composite/acrylic veneer crown/pontic, indirect	09.00		100.714	822.50 (721.50)
9557	Composite/acrylic jacket crown, indirect	09.00		71.143	581.00 (509.70)
9559	Composite/acrylic veneer post crown	09.00		99.571	813.20 (713.30)
9560	Indirect Composite Resin Veneer	09.00		42.143	344.20 (301.90)
9561	Composite/acrylic jacket crown, direct	09.00		48.571	396.70 (348.00)
9563	Temporary acrylic/composite crown per unit	09.00		34.714	283.50 (248.70)
9564	Heat formed template supplied to dentist for the manufacture of temporary restorations	09.00		17.429	142.30 (124.90)
9565	Composite/acrylic-facing replaced	09.00		40.429	330.20 (289.60)
9566	Porcelain/ Ceromer facing replaced	09.00		73.286	598.50 (525.00)
9569	Waxing of crown to existing denture	09.00		28.571	233.30 (204.70)
9570	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate	09.00	+	29.429	240.30 (210.80)
5	**Orthodontic Appliances**				
	The tariffs under this section excludes the tariff for models.				09.00
	The following section includes consumables, however it excludes materials				09.00
A	**Orthodontic Services**				
9571	Basic charge which includes acrylic base	09.00		36.143	295.20 (258.90)
9572	Basic charge non acrylic base	09.00		17.429	142.30 (124.90)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9573	Additional charge for fitting first expansion screw	09.00	+	6.857	56.00 (49.10)
9575	Additional fee for fitting subsequent expansion screws	09.00	+	5.857	47.80 (42.00)
9576	Additional fee for full aclusal bite plate	09.00	+	20.286	165.70 (145.30)
9577	Additional fee for bite plate anterior	09.00	+	6.857	56.00 (49.10)
9578	Additional fee for bite plate posterior	09.00	+	6.857	56.00 (49.10)
9579	Additional fee for fitting tongue guard	09.00	+	8.571	70.00 (61.40)
9581	Additional fee for flat or inclined plane	09.00	+	5.286	43.20 (37.90)
9583	Additional fee for Adams Crib	09.00	+	6.286	51.30 (45.00)
9585	Additional fee for Jackson Crib	09.00	+	6.571	53.70 (47.10)
9587	Additional fee for ball clasp	09.00	+	7.429	60.70 (53.20)
9589	Additional fee for single arm clasp	09.00	+	5.714	46.70 (40.90)
9591	Additional fee for double arm clasp	09.00	+	10.000	81.70 (71.60)
A.1	**Springs**				
9593	Additional fee for fitting single loop finger spring	09.00	+	4.714	38.50 (33.80)
9595	Additional fee for fitting double loop finger spring	09.00	+	5.571	45.50 (39.90)
9597	Additional fee for fitting Buccal retraction spring	09.00	+	4.143	33.80 (29.70)
9599	Additional fee for fitting apron spring	09.00	+	10.714	87.50 (76.80)
9603	Additional fee for fitting coffin spring	09.00	+	10.286	84.00 (73.70)
9605	Additional fee for fitting Quad Helix	09.00	+	11.429	93.30 (81.90)
9607	Additional fee for fitting flapper or "T"-spring	09.00	+	8.571	70.00 (61.40)
9609	Additional fee for fitting all springs with tubing, each	09.00	+	9.571	78.20 (68.60)
A.2	**Arches**				
9611	Additional fee for fitting labial arch	09.00	+	5.429	44.30 (38.90)
9613	Additional fee for fitting buccal arch	09.00	+	6.429	52.50 (46.10)
9615	Additional fee for fitting Roberts retractor	09.00	+	12.000	98.00 (86.00)
9617	Invisible Retainer	09.00		15.857	129.50 (113.60)
9619	Additional fee for fitting twin wire arch extra-oral arch	09.00	+	15.000	122.50 (107.50)
9620	Additional fee Lip bumper	09.00	+	6.286	51.30 (45.00)
9621	Additional fee for fitting extra-oral arch	09.00	+	14.286	116.70 (102.30)
9622	Additional fee for fitting space maintainer arch	09.00	+	6.286	51.30 (45.00)
A.3	**Welding And Soldering**				
9623	Additional fee for each spot-welding joint	09.00	+	2.857	23.30 (20.50)
9625	Additional fee for each soldering joint	09.00	+	4.571	37.30 (32.70)
9627	Additional fee for each invested soldering joint	09.00	+	12.714	103.80 (91.10)
9629	Additional fee for each hook for elastic traction	09.00	+	4.143	33.80 (29.70)
B	**Mouth Protectors and MYO Functional Appliances**				
9631	Mouth protector (gum guard)	09.00		26.857	219.30 (192.40)

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9633	Oral Screen	09.00		33.000	269.50 (236.40)
9635	Andresen or Norwegian appliance	09.00		59.000	481.90 (422.70)
9637	Tooth positioner	09.00		68.000	555.40 (487.20)
9639	Gunning splint	09.00		90.571	739.70 (648.90)
9641	Frankel appliance	09.00		87.429	714.00 (626.30)
9643	Chin cap	09.00		29.000	236.80 (207.80)
9645	Bionator	09.00		59.143	483.00 (423.70)
9646	Diagnostic set-up	09.00		56.857	464.40 (407.30)
9647	Snoring Appliance	09.00		53.714	438.70 (384.80)
C	**Fixed Appliances**				
9651	Pinched or swaged band with welded attachment (excluding cost of attachment)	09.00		17.429	142.30 (124.90)
9653	Pinched or swaged band with soldered attachment	09.00		22.857	186.70 (163.70)
D	**Additional Services**				
9662	Additional fee for each remake at an agreed quantum of time to be calculated at an hourly rate	09.00	+	29.429	240.30 (210.80)
6	**Materials**				
A	**Prosthetic/Restorative Services**				
9700	Diatorics 1 X 6/8	09.00		-	-
9702	Diatorics, odds, anterior	09.00		-	-
9704	Diatorics, odds, posterior	09.00		-	-
9706	Cost of Bleaching tray material	09.00		-	-
9720	Soft base material per denture	09.00		-	-
9722	Acrylic per denture	09.00		-	-
9724	Cost of precision attachment, per attachment	09.00		-	-
9726	Preformed Ball or Roach Clasp	09.00		-	-
9728	Cost of lingual / palatal bar	09.00		-	-
9729	Cost of mesh strengthener	09.00		-	-
9730	Cost of pre-fabricated burn-out component, per component	09.00		-	-
9732	Cost of other attachment components e.g. Nylon caps, sleeves etc	09.00		-	-
9734	Cost of dolder bar and clips, per gram or per clip	09.00		-	-
9736	Cost of implant components	09.00		-	-
9738	Cost of preformed strengthener	09.00		-	-
9739	Additional Charge Gold plating	09.00	+	-	-
B	**Metal**				
9740	Cost of gold wire, per gram	09.00		-	-
9741	Cost of Cobalt Chrome casting alloy	09.00		-	-
9742	Cost of specialised Cobalt Chrome casting metal e g Vitallium, Titanium	09.00		-	-
9744	Cost of precious casting alloy	09.00		-	-
9746	Cost of semi-precious casting alloy	09.00		-	-
9748	Cost of non-precious casting alloy	09.00		-	-
9752	Cost of platinum foil	09.00		-	-
9754	Cost of gold solder, per gram	09.00		-	-
9755	Etching For bonding (metal or Ceramic)	09.00		-	-
9756	Cost of silver solder, per gram	09.00		-	-
9757	Ceromer material - per unit	09.00		-	-
9758	Fiber re-enforced material per unit	09.00		-	-
9760	Composite restoration material	09.00		-	-
9761	Ceramic material	09.00		-	-
C	**Orthodontic Services**				
9762	Cost of anterior orthodontic attachment, per attachment	09.00		-	-
9763	Orthodontic material	09.00		-	-
9764	Cost of posterior orthodontic attachment, per attachment	09.00		-	-
9765	Preformed components	09.00		-	-
9766	Cost of expansion screw, per screw	09.00		-	-
9767	Soldering material	09.00		-	-
9768	Cost of buccal tube/transfer tube, per tube	09.00		-	-

Code	Description	Ver	Add	Dental Technology	
				RVU	Fee
9770	Cost of J-hook, per hook	09.00		-	-
9772	Cost of lingual buttons, per button	09.00		-	-
9774	Cost of invisible retainer material	09.00		-	-
9775	R/A case	09.00		-	-
9776	Cost of mouth protector material	09.00		-	-
9778	Cost of arch wire	09.00		-	-
9779	Dual laminate material	09.00		-	-
7	**Precision Attachments and Implant Services**				
	The following section includes consumables, however it excludes materials				09.00
9780	Positioning and finishing of complete (male and female) pre-fabricated burn-out attachment	09.00		45.000	367.50 (322.40)
9782	Positioning and soldering of complete (male and female) precision attachment	09.00		37.571	306.80 (269.20)
9783	Implant stent per unit	09.00		34.714	283.50 (248.70)
9784	Alignment of dolder bar and clips	09.00		47.429	387.40 (339.80)
9786	Trimming, waxing and finishing of implant abutment - crown and bridge work only, per abutment	09.00		20.429	166.80 (146.40)
9787	Waxing, milling and finishing of a custom abutment	09.00		39.857	325.50 (285.50)
9788	Implant superstructure (edentulous cases) including placing of preformed parts, per section cast	09.00		217.857	1779.20 (1560.70)
9789	Finishing of prosthesis on implant structure per arch	09.00		79.571	649.90 (570.00)

DENTAL THERAPISTS

Dental Therapy 2009

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DENTAL THERAPISTS EFFECTIVE FROM 1 JANUARY 2009

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.

In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.

VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

001	Item 001 refers to a Full Mouth Examination, charting and treatment planning and no further fee shall be chargeable until the treatment plan resulting from this consultation is completed.	06.03
002	(a) Every dental therapist shall render a monthly account for every procedure which has been completed irrespective of whether the total treatment plan has been. (b) Every account shall contain the following particulars : (i) the surname and initials of the member; (ii) the first name of the patient; (iii) the name of the scheme; (iv) the membership number of the member; (v) the practice number; (vi) date on which every service was rendered; (vii) where the account is a photocopy of the original, certification by way of a rubberstamp or the signature of the dental therapist ; (viii) a statement of whether the account is in accordance with the National Reference Price List ; (ix) the name of the dental therapist rendering the service must be shown on the account;and (x) the relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered;.	06.03
003	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	06.03

ITEMS

Code	Description	Ver	Dental Therapy	MP	Lab	TC
8139	Appointment not kept /30min	06.03	-			B
	Comment: By arrangement with patient					
8109	Infection control/barrier techniques	06.03	11.40 (10.00)			B
	Comment: This is typically reported on a "per visit" basis for new rubber gloves, masks, etc. provided by the dentist. Report per provider per visit.					
8110	Sterilized instrumentation	06.03	29.40 (25.80)			S
	Limitation: The use of this code is limited to autoclaved, vapour or heat sterilised instruments (i.e. set(s) of long handled instruments and/or forceps) provided by the dentist/hygienist for use in the surgery. Report per visit.					
8120	Treatment plan completed	06.03	-			
	Use to report the completion of a treatment plan effected from an oral evaluation – See Rule 008.					
Diagnostic services						
8101	Oral examination	06.03	65.90 (57.80)			B
	An assessment performed on a patient to determine the patient's dental and medical health status involving an examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. This procedure is also used to report a periodic examination on an established patient to determine any changes in a patient's dental and medical health status since a previous periodic or comprehensive examination. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008).					

Code	Description	Ver	Dental Therapy	M P	Lab	T C
8102	Comprehensive oral examination	06.03	106.40 (93.40)			B
	An assessment performed on a new or established patient (patient of record) to determine the patient's dental and medical health status involving a comprehensive examination, diagnosis and treatment plan. It is a thorough assessment and recording of the patient's past and current state of oral health (extraoral and intraoral hard and soft tissues), risk for future dental disease as well as assessing general health factors that relate to the treatment of the patient. A comprehensive examination includes treatment planning at a separate appointment where a diagnosis is made with information acquired through study models, full-mouth x-rays and other relevant diagnostic aids. It includes, but is not limited to the evaluation and recording of dental caries, pulp vitality tests of the complete dentition, plaque index, missing and unerupted teeth, restorations, occlusal relationships, periodontal conditions (including a periodontal charting and bleeding index), hard and soft tissue anomalies (including the TMJ). The patient shall be provided with a written comprehensive treatment plan, which is a part of the patient's clinical record and the original should be retained by the dentist. No further oral examination fees shall be levied until the treatment plan resulting from this assessment is completed (See Rule 008)					
8104	Limited oral examination	06.03	51.40 (45.10)			B
	An assessment performed on a new or established patient (patient of record) involving an examination, diagnosis and treatment plan, limited to a specific oral health problem or complaint. This type of assessment is conducted on patients who present with a specific problem or during an emergency situation for the management of a critical dental condition (e.g., trauma and acute infections). It includes patients who have been referred for the management of a specific condition or treatment such as the removal of a tooth, a crown lengthening or isolated grafting procedure where there is no need for a comprehensive assessment. Comment: This code should not be reported on established patients who present with specific problems/emergencies which is part of and/or a result of the patients' current treatment plan, e.g., recementation/replacement of temporary restorations, pain relief during root canal treatment, etc.					
8189	Re-examination - existing condition	06.03	51.40 (45.10)			B
	An assessment performed on an established patient (patient of record) to assess the status of an untreated previously existing condition involving an examination and evaluation, limited to the previously existing condition. This type of assessment is conducted on patients (1) with a traumatic injury where no treatment was rendered but the patient needs follow-up monitoring; (2) requires evaluation for undiagnosed continuing pain after a limited oral examination and diagnostic tests did not reveal any findings; and (3) with soft tissue lesions such as a leukoplakia observed on a previous visit that require follow-up monitoring of pathological changes. Comment: (1) A re- examination is not a post-operative visit.					
8129	Office/hospital visit – after regularly scheduled hours	06.03	158.20 (138.80)			B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report in addition to appropriate code numbers for actual services rendered. After regularly scheduled hours is definend as weekends and night visits between 18h00 and 07h00 the following day. Limitation: Code 8129 may only be reported for emergency treatment rendered outside normal working hours. Not applicable where a practice offers an extended hours service as the norm.					
8140	House/extended care facility/hospital call	06.03	104.60 (91.80)			B
	Includes visits to nursing homes, long-term care facilities, hospice sites, institutions, etc. Report per visit in addition to reporting appropriate code numbers for actual services performed. Limitation: The fee/benefit for house/extended care facility/hospital calls are limited to five calls per treatment plan.					
8190	Consultation - second opinion or advice	06.03	-			B
	A consultation is a diagnostic service rendered by a dentist, other than the practitioner providing treatment, whose opinion or advice for the purpose of determining the patient's dental needs and proposing treatment regarding a specific problem is requested. A consultation requires and includes a written report to the practitioner or patient who requested the consultation. It involves an examination, diagnosis and treatment proposal. The dentist may initiate further diagnostic or therapeutic services (oral examinations excluded). Comment: A referral is the transfer of the total or specific care of a patient from one dentist to another and does not constitute a consultation. When the consulting dentist assumes responsibility for the continuing care of the patient, any service rendered by him/her will cease to be a consultation, and an appropriate oral examination code should be reported. Code 8106 (special report) may not be reported in addition to this code					
Radiographs/diagnostic imaging						
8107	Intraoral radiograph - periapical	06.03	49.40 (43.40)			B
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.					
8108	Intraoral radiographs - complete series	06.03	396.80 (348.00)			B
	A complete series consists of a minimum of eight intraoral radiographs, periapical and or bitewing, occlusal radiographs excluded.					

Code	Description	Ver	Dental Therapy	M P	Lab	T C
8112	Intraoral radiograph - bitewing	06.03	49.40 (43.40)			B
	Eight and more radiographs of any combination of Codes 8107 and 8112 taken on the same date of service for diagnostic purposes are considered to be a complete intraoral series (8108) and should be submitted as such.					
8113	Intraoral radiograph - occlusal	04.00	85.00 (74.60)			B
8114	Extraoral radiograph - hand-wrist	06.03	-			B
	Use to report extraoral radiographs such as hand-wrist radiographs.					
8115	Extraoral radiograph - panoramic	04.00	197.80 (173.50)			B
8116	Extraoral radiograph - cephalometric	05.02	197.80 (173.50)			B
8118	Extraoral radiograph - skull/facial bone	05.02	-			B
8121	Oral and/or facial image (digital/conventional)	06.03	53.00 (46.50)			B
	This includes traditional photographs and digital intra- or extraoral images obtained by intraoral cameras. These images should only be reported when taken for clinical/diagnostic reasons and shall be retained as part of the patient's clinical record. Excludes conventional radiographs.					
Preventive services						
	Note : Items 8159, 8155, 8161 and 8162 may not be charged more than once in six months per patient. Where item 8159 is applied, item 8155 may not be charged. Item 8151 and 8153 may not be charged to patients under 9 years of age.					06.03
8151	Oral hygiene instruction	06.03	51.70 (45.40)			B
	The dental knowledge of the patient/parent to prevent oral diseases should be evaluated before oral hygiene instructions is provided e.g., do they know what is dental plague, how can it be removed, what is fluoride, how does fluoride work to prevent dental caries, how can fluoride be used and what is a dental sealant. An oral hygiene instruction may include, but is not limited to: Plaque control information, e.g. instruction pamphlets or leaflets; Dietary instructions; Explanation and demonstration of plaque control (brushing and flossing); Self-practice session in the mouth under professional supervision; Use of special aids such as disclosing agents; and Scoring of plaque levels (plaque index). The patient must be informed prior to the service being rendered that a fee will be levied for oral hygiene instruction. Oral hygiene instructions to a child should take place in the presence of a parent and/or guardian.					
8153	Oral hygiene instruction - each additional visit	06.03	37.90 (33.20)			B
	Report code 8153 when additional oral hygiene instructions is required as part of the treatment plan. No other preventive services may be reported at the same visit. See code 8151					
8155	Polishing - complete dentition	06.03	63.30 (55.50)			B
	A polishing involves the removal of stains and plaque from the clinical crowns of natural teeth, and making the surface smooth and glossy, to help minimise the loss of enamel and decrease the possibility of damage to restorations. Includes the complete primary, transitional or permanent dentition. This code should not be used concurrent with codes 8159 or 8160. See code 8157 in the restorative section for the re-burnishing and polishing of restorations.					
8159	Prophylaxis - complete dentition	06.03	115.30 (101.10)			B
	A prophylaxis involves a series of procedures whereby calculus, stain, and other accretions are removed from the clinical crowns of teeth. A prophylaxis includes, but is not limited to a scaling and polishing of the complete primary, transitional or permanent dentition. Code 8159 should not be used concurrent with code 8155 or 8160.					
8161	Topical application of fluoride - child	06.03	63.30 (55.50)			B
	To be used for treatment of complete dentition to prevent dental decay. Report code 8167 in the miscellaneous section when fluoride is used as desensitising medicament. Should not be used concurrent with code 8167. A patient is defined as an adult beginning at age 12.					
8162	Topical application of fluoride - adult	06.03	63.30 (55.50)			B
	See code 8161.					
8163	Dental sealant	06.03	46.90 (41.10)	T		B
	Also known as pit-and fissure sealant. This procedure involves the mechanical and/or chemical preparation of an occlusal enamel surface and placement of a material to seal decay-prone pits, fissures, and grooves of a tooth. A preventive resin restoration is distinguished from a sealant in that in a restorative the decay penetrates into dentin. If the caries is limited to the enamel, it is still considered a sealant. Limitation: Certain funders limit benefits for sealants to two teeth per quadrant.					
	Note : 8163 chargeable once only in respect of a tooth per annum. 8163 apply to individuals below 21 years of age. Fee for patients over 21 years of age by arrangement with scheme.	06.03				

Code	Description	Ver	Dental Therapy	MP	Lab	TC
Extractions during a single visit.						
8201	Extraction - tooth or exposed tooth roots (first per quadrant)	06.03	73.80 (64.80)	T		B
	The removal of an erupted tooth or exposed tooth roots by means of elevators and/or forceps. This includes the routine removal of tooth structure and suturing when necessary. Report per tooth. The removal of more than one exposed root of the same tooth should be reported as one extraction. When a normal extraction fails and residual tooth roots are surgically removed during the same visit, code 8937 should be reported.					
8202	Extraction - each additional tooth or exposed tooth roots	06.03	28.50 (25.00)	T		B
	To be reported for an additional extraction in the same quadrant at the same visit.					
8145	Local anaesthetic - per visit	06.03	11.20 (9.83)			B
	Use for infiltrative anaesthesia (anaesthetic agent is infiltrated directly into the surgical site by means of an injection). Excludes topical anaesthesia (anaesthetic agent is applied topically to the mucosa/skin). Report per visit. Comment: The fee for topical anaesthesia are considered to be part of, and included in the fee for the local anaesthesia (injection). Code 8145 includes the use of the Wand.					
8220	Cost of suture material	06.03	-			B
	Comment: Use in conjunction with procedure(s) when suture material is provided by the practitioner. Report per pack. See Rule 002 and Modifier 8025 for direct material costs.					
8931	Treatment of post-extraction haemorrhage	06.03	48.10 (42.20)			S
	Involves the treatment of local haemorrhage following extraction. Report per visit. Excludes treatment of bleeding in the case of blood dyscrasias (8933), e.g. haemophilia. Routine post operative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for the surgical service.					
8935	Treatment of septic socket	06.03	48.10 (42.20)			S
	Involves the treatment of localised inflammation of the tooth socket following extraction due to infection or loss of blood clot; osteitis. Report per visit. Routine postoperative visits for irrigation, dressing change and suture removal are considered to be part of, and included in the fee for, the surgical service.					
9011	Incision & drainage of abscess - intra-oral (pyogenic)	05.02	90.90 (79.70)	M		S
8303	Pulp cap - indirect	06.03	93.60 (82.10)	T		B
	This procedure involves the covering of the nearly exposed pulp with a protective material to protect it from external irritants and to promote healing. Excludes the final restoration.					
Amalgam restorations (including polishing).						
8341	Amalgam - one surface	04.00	135.10 (118.50)	T		B
8342	Amalgam - two surfaces	04.00	166.50 (146.10)	T		B
8343	Amalgam - three surfaces	04.00	203.00 (178.10)	T		B
8344	Amalgam - four or more surfaces	04.00	226.10 (198.30)	T		B
	Only one of the above items may be charged per tooth within a year.	06.03				
Resin restorations (using resin bonding technique)						
8351	Resin - one surface, anterior	04.00	163.40 (143.40)	T		B
8352	Resin - two surfaces, anterior	04.00	205.40 (180.20)	T		B
8367	Resin - one surface, posterior	06.03	177.20 (155.40)	T		B
	This is not a preventative procedure and should only be used to restore a carious lesion or a deeply eroded area into a natural tooth. See also code 8163 - sealant.					
8369	Resin - three surfaces, posterior	04.00	264.80 (232.20)	T		B
8370	Resin - four or more surfaces, posterior	04.00	284.80 (249.80)	T		B
8368	Resin - two surfaces, posterior	04.00	219.20 (192.30)	T		B
8353	Resin - three surfaces, anterior	04.00	245.50 (215.40)	T		B
8354	Resin - four or more surfaces, anterior	06.03	274.00 (240.40)	T		B
	Use to report the involvement of four or more surfaces or the incisal line angle. The Incisal line angle is the junction of the incisal and the mesial or distal surface of an anterior tooth.					

Code	Description	Ver	Dental Therapy	MP	Lab	TC
8350	Resin crown - anterior primary tooth (direct)	06.03	294.60 (258.40)	T		B
	This procedure involves the full coverage of an anterior primary tooth with a resin based material.					
	Note: Only one of the above codes may be charged per tooth within a year.	06.03				
Palliative Treatment						
8131	Emergency dental treatment	06.03	65.90 (57.80)	T		B
	This code is intended to be used for emergency treatment to alleviate dental pain but is not curative - report per visit. This code should not be used when more adequately described procedures exists and may not be reported with other procedure codes (diagnostic procedures and professional visits excluded).					
8165	Sedative filling	06.03	65.90 (57.80)	T	+L	B
	The intention of this code is to report a temporary restoration to relieve pain. It should not be used as a temporary restoration in conjunction with root canal therapy, a base or liner under a restoration. Use this code to report a ZOE restoration or ART technique. May not be reported with other procedure codes on the same visit for a tooth.					
8166	Application of desensitising resin, per tooth	06.03	43.50 (38.20)	T		B
	This procedure involves the application of adhesive resins on a cervical and/or root surface and should not to be used for bases, liners, or adhesives under restorations - report per tooth.					
8167	Application of desensitising medicament, per visit	06.03	50.70 (44.50)			B
	This procedure involves the application of topical fluoride on teeth and/or root surfaces and should not to be used for bases, liners, or adhesives under restorations - report per visit (irrespective of number of teeth treated). The intention of this code is to treat persistent pain and not to prevent decay. Fluoride application is considered treatment for caries control – See codes 8161 and 8162. Comment: This code should not be reported together with codes 8161 and 8162.					

DIETICIANS

Dieticians 2009

NATIONAL REFERENCE PRICE LIST FOR SERVICES BY DIETICIANS EFFECTIVE FROM 1 JANUARY 2009

The following reference price list is not a set of tariffs that must be applied by medical schemes and/or providers. It is rather intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the national health reference price list. It is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes. Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.
In calculating the prices in this schedule, the following rounding method is used: Values R10 and below rounded to the nearest cent, R10+ rounded to the nearest 10cent. Modifier values are rounded to the nearest cent. When new item prices are calculated, e.g. when applying a modifier, the same rounding scheme should be followed.
VAT EXCLUSIVE PRICES APPEAR IN BRACKETS.

GENERAL RULES

003	Dietary services are per individual patient.	04.00
004	Each practitioner must acquaint him-/herself with the provisions of the Medical Schemes Act, as amended, and the regulations promulgated under the Act and shall render a monthly account in respect of any service rendered during the month, irrespective of whether or not the treatment has been completed. NB. Every account shall contain the following particulars · The name and practice code number of the referring practitioner. · The name of the member. · The name of the patient. · The name of the medical scheme. · The membership number of the member. · The nature of the treatment. · The date on which the service was rendered. · The relevant diagnostic codes and NHRPL item code numbers relating to the health service rendered.	04.00
005	When multiple diagnoses apply every applicable diagnosis shall be specified on the statement.	04.00
010	It is recommended that, when such benefits are granted, drugs, consumables and disposable items used during a procedure or issued to a patient on discharge will only be reimbursed by a medical scheme if the appropriate code is supplied on the account.	04.00
011	Compilation of reports is only to be included within billable time if these reports are for purposes of motivating for therapy and/or giving a progress report and/or a pre-authorisation report, and where such a report is specifically required by the medical scheme. Maximum billable time for such a report is 15 minutes.	05.03

MODIFIERS

0021	Services to hospital inpatients: Quote modifier 0021 on all accounts for services performed on hospital inpatients.	04.00

ITEMS

1. INDIVIDUAL ASSESSMENT, COUNSELLING AND/OR TREATMENT

Code	Description	Ver	Add	Dietetics RVU	Dietetics Fee
107	Appointment not kept (schemes will not necessarily grant benefits in respect of this item, it will fall into the "By arrangement with the scheme" or "Patient own account" category).	04.00			
200	Nutritional assessment, counselling and/or treatment. Duration: 1-10min.	05.03		0.500	26.80 (23.50)
201	Nutritional assessment, counselling and/or treatment. Duration: 11-20min.	05.03		1.500	80.30 (70.40)
202	Nutritional assessment, counselling and/or treatment. Duration: 21-30min.	05.03		2.500	133.80 (117.30)
203	Nutritional assessment, counselling and/or treatment. Duration: 31-40min.	05.03		3.500	187.30 (164.30)
204	Nutritional assessment, counselling and/or treatment. Duration: 41-50min.	05.03		4.500	240.80 (211.20)
205	Nutritional assessment, counselling and/or treatment. Duration: 51-60min.	05.03		5.500	294.30 (258.10)
206	Nutritional assessment, counselling and/or treatment. Duration: 61-70min.	05.03		6.500	347.80 (305.00)
207	Nutritional assessment, counselling and/or treatment. Duration: 71-80min.	05.03		7.500	401.30 (352.00)
208	Nutritional assessment, counselling and/or treatment. Duration: 81-90min.	05.03		8.500	454.80 (398.90)
209	Nutritional assessment, counselling and/or treatment. Duration: 91-100min.	05.03		9.500	508.30 (445.80)
210	Nutritional assessment, counselling and/or treatment. Duration: 101-110min.	05.03		10.500	561.80 (492.80)
211	Nutritional assessment, counselling and/or treatment. Duration: 111-120min.	05.03		11.500	615.30 (539.70)

2. GROUP ASSESSMENT, COUNSELLING AND/OR TREATMENT

	Group nutritional assessment, counselling and/or treatment items are chargeable to a maximum of 12 patients.				05.03
300	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 1-10min.	05.03		0.100	5.35 (4.69)
301	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 11-20min.	05.03		0.300	16.10 (14.10)
302	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 21-30min.	05.03		0.500	26.80 (23.50)

Code	Description	Ver	Add	Dietetics	
				RVU	Fee
303	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 31-40min.	05.03		0.700	37.50 (32.90)
304	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 41-50min.	05.03		0.900	48.20 (42.20)
305	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 51-60min.	05.03		1.100	58.90 (51.60)
306	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 61-70min.	05.03		1.300	69.60 (61.00)
307	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 71-80min.	05.03		1.500	80.30 (70.40)
308	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 81-90min.	05.03		1.700	91.00 (79.80)
309	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 91-100min.	05.03		1.900	101.70 (89.20)
310	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 101-110min.	05.03		2.100	112.40 (98.60)
311	Group nutritional assessment, counselling and/or treatment, per patient. Duration: 111-120min.	05.03		2.300	123.10 (107.90)